



WHAT COMPELLED ME TO TAKE PART IN THIS STUDY

A friend alerted me to the call for participation in this project, and although I am a health practitioner, I immediately resonated with the objectives of this research. I have been interested in the long-term health and psychological consequences of violence and trauma on the people who survive it for close to two decades. The physical and emotional ramifications of having lived through trauma, particularly repeated trauma (Bloom, 1997; Herman, 1992; Ogden et al., 2006; van der Kolk, 1996), can become prominent when people require health services, because injury and illness can make people feel a total loss of control, a feeling reminiscent of the abuse. In my clinical work, I have witnessed countless patients struggle to follow directions, to learn new information, and to ask for, sometimes even to know, what they need. Some people may be guarded or suspicious, forgetful or passive, while others may tend to be demanding or aggressive. People with histories of overwhelming traumas may describe physical symptoms that shatter the typical patterns clinicians expect to see for certain conditions. These apparent inconsistencies and the intensity of these patients' behaviours often confuse or frustrate practitioners. Practitioners do not operate in a vacuum, and anyone who has interacted with the medical system knows it is complicated and filled with rules of operation and expectations for behaviour. While the dominant assumptions and principles of our health systems and professional schools shed much light on how clinicians behave and come to practise their professions, a look at health care context is beyond the scope of this paper. (See Deborah R. Gordon's *Tenacious Assumptions in Western Medicine*, 1988, for one clear description of the values upheld and dismissed by the health system.)

Over the years, I've noted that patients who did not follow the professional's instructions (to exercise properly, maintain their sugar-free diet, use a cane to steady their wobbly gait) were often labelled as "unmotivated." They might even be discharged from a service, ostensibly to make room for other more "motivated" patients. Practitioners seemed angry, exasperated or frustrated when a patient did not follow their suggestions. But seldom did we, as practitioners, explore what made it difficult for patients to

Navigating Practitioner Discomfort: Reflections on Power and Self-Care



follow through; or whether our suggestions had meaning to patients; or whether our approach was congruent with the expressed needs of these patients. Professionals usually have been taught and often assume that recommendations follow objective criteria that establish them as “the right thing to do.”

I invariably felt sad and angry as colleagues discussed a patient’s “absence of motivation” to get well or their “non-compliance.” I became aware that once a patient was described as non-compliant or unmotivated, this conception of the person was engraved in the written record and easily spread among co-workers. I repeatedly watched these words wedge the gap of understanding even wider between the practitioner and the patient. It puzzled me that we were not curious about why our recommendations were not followed. Our gaze was fixed on the other, and I don’t recall ever engaging in an exploration of how a patient’s response to us made us feel as professionals. There was no such space created for reflection (see Rita Charon’s “The Parallel Chart” in *Narrative Medicine*, 2006). What was it about so-and-so that elicited a strong response from one practitioner but not another? Did we have unacknowledged or unresolved issues that lay beneath our awareness and yet influenced our own reactions and behaviours?¹ Our need to be

*“Saving Fish from Drowning”**

A word about intention

Typically, practitioners intend to “do good” and to “mean no harm.” Our absence of intent to hurt, however, does not guard us against causing harm. Assuaging ourselves in our good intention, we are not introspective about our behaviour and harm may be perpetuated. Reliance on our good intentions become the blinders and rationale to leave our power, our own feelings and our behaviours unexamined. Intention cannot stand alone, but must be accompanied by awareness to best guard those we serve against our abusing that power. The more vulnerable the patient, the more critical it is that they be treated by a provider who is conscious of these power dynamics. Our attempt to protect ourselves from feeling bad by reassuring ourselves that we “did it for their own good” is ill-conceived. (See Alice Miller’s *For Your Own Good*, 1988, for her detailed exploration of the violence that hides behind that phrase.)

*This metaphor is from the title of Amy Tan’s novel *Saving Fish from Drowning* (G. P. Putnam’s Sons, 2005).

seen as competent may be one example. The need to be liked by patients and by each other may be another, as well as our need to get things right. Our need to control situations. Our need to have certainty and to fix things. Our need to help others. Our need to be seen as good people. As caring people. As people who do difficult work well, often without systemic support. Notwithstanding the frustrations, we were strangely married to being perpetually “positive,” and we most definitely were silent on our need to avoid our own pain as it emerged through our work with others.

Awareness, in ever deepening levels, is our best tool to protect the people we serve from our causing them unintentional harm. Nothing is foolproof, however, and the integrity of our professionalism demands that we acknowledge relationship ruptures when they occur (Peterson,

Falling through the Cracks?

A friend whose mother had recently died related immediately to this project when I spoke about the consequences of clinicians' own needs going unacknowledged by them. She told me that some time earlier, her mother had attended a diagnostic procedure. The technician was harried, and when he routinely explained how the test is done, her mother panicked and said she didn't think she could do it. "Well, you don't have to do it," he replied. Options to make it easier for her were not explored. The test never happened.

When professionals dismiss the power of our roles in the eyes of patients, we don't take seriously the effects of our words and actions. What systemic processes might facilitate this absence of due care by this technician? What got in the way of the practitioner taking the necessary time to uncover what adjustments might make the test easier

for my friend's mother? (One practitioner cited in this report spoke of the systemic drive for efficiency.) For years I have noted an almost carefree use of the notion of "patient choice" and "patient-centred" care in medical parlance. I wondered if this clinician would explain that the patient "chose" not to have the test, and that he respected her wishes. Had he explored her fears, offered accommodation as was possible, provided strategies to mitigate her anxiety, explained the consequence of not pursuing this test, and after such dialogue she was still unable to continue, I might concur that it was her "choice." Such was not the case. Once professionals acknowledge the power differential, boundary violations of this nature come to light. I believe that the technician's needs got in the way of this woman's care. The woman's stomach cancer was discovered one and a half years after the test that didn't happen. By then the cancer was at the advanced stages, and she died from it 10 months later.

1992). Research underscores that it is imperative for practitioners to monitor their feelings and reactions to the people who seek their services (Charon, 2006; Frank, 1995; Kuhl, 2002; Meier et al., 2001; Peterson, 1992; Stein, 1985). How clinicians manage these emotions becomes critical to the effectiveness of the care they provide (Kuhl, 2002; Meier et al., 2001; Stein, 1985).

The dynamics of patient-health clinician share similarities with the literacy practitioner-learner relationship. Because of the relevance I saw between this literacy project and health practice, I chose to focus my inquiry on the practitioner-patient relationship, hoping that there would be enough commonality in the parameters of the relationship itself to be of service to literacy practitioners.

WHO AM I?

I am a 49-year-old, white, Montreal-born woman who came to a feminist consciousness in my third decade on this planet. As a physiotherapist, I have worked with people with complex medical and palliative conditions, people with multiple traumas and people who are survivors of violence. I have been very curious about how our bodies store our life experiences and how our muscles, joints and organs hold emotions we've been trained not to express. I am forever intrigued by the healing

possibilities of the practitioner-patient relationship. Also true is that I have been disheartened by the relentless number of stories I've heard from patients, friends and strangers about distressing exchanges with health professionals. Were there common threads, I wondered, underlying these stories?

My specific desire in this project, to focus on practitioners' awareness of their power and of their inner emotional landscape, arose from my own experience as a practitioner in one poignant and life-altering exchange about 15 years ago. This exchange was a watershed for me in my awareness of my needs and feelings as a practitioner. It crystallized for me the power I wield in another person's eyes in that role. I offer this story here as it was a critical experience for me in thinking about who I am as a professional and what happens when my needs are put to the test. It describes some of the subtleties of power dynamics, and the themes that emerged from this experience assisted me in developing the questions I brought to the health practitioners I interviewed for this project. The story was written in 1997, though the incident occurred about five years earlier.

LANCEY: CATCHING MYSELF

One afternoon I was approached by the instructor, who thought Lancey might be having seizures. Lancey would stare off into space, apparently unable to hear, then she would return to her lesson. As the only health professional in a project that taught life skills to people with disabilities, I was called in to investigate. Lancey had spent much of her 30-something years in institutions. She used a wheelchair to get around and lived in a group home with nursing care. Lancey was slow to process new information and often required repetition to learn simple tasks. I decided to broach the topic of seizures delicately, sensing that my concern might frighten her. Lancey engaged readily in the discussion and told me she was on medication for epilepsy. The dosage, however, had not been reviewed for years, and Lancey had little understanding of epilepsy. I suggested that we learn together and request information from the local epilepsy association. Lancey went along with my idea.

A week later, I met with Lancey again, buoyed by a sense of self-congratulation for my novel approach with her. I hoped to engage Lancey in discussion and shared learning, as opposed to lecturing her. Eagerly, I removed the materials from the envelope and read the titles of the pamphlets aloud. "Epilepsy and the Workplace," "Medications for Epilepsy," I continued, until I finally looked up. My heart skipped a beat as my eyes caught the wet, wide eyes of beet-faced Lancey. With uncharacteristic candidness, this soft-spoken, agreeable woman furiously blurted, "Shayna, you're pushing me!" The moments that followed were suspended, as though unfolding in slow motion. I registered my whole body tightening and a flash of anger at Lancey. After all, wasn't I not only worried about her health but equally concerned that I be sensitive to her fears? As these thoughts raced through me, so did the slower dawning of my need for her gratitude. Though it was a struggle to admit it, I suddenly became clear of the self-righteousness I brought to these encounters with her. I watched a wave come over Lancey; her face lost its tightness, the flaming colour receded, her eyes softened. Then another shift in her, and I registered fear on her face. Seeing her fear rattled me. A stream of apologies then spilled out of her as if to coat earlier words that had escaped before she could swallow them. It was as though she came to her senses and remembered her subordinate place. Lancey seemed to instinctively know that her spontaneous

anger, however honest, was forbidden with a professional. As though compelled by instinct, she began to heap praise on me, as if to ensure that I felt good about my work with her. I *had* been feeling quite proud of myself up until that point, so her behaviour was right on. Conditioned by her many years of interactions with health care workers, she knew, consciously or not, that her authentic reaction of anger could be dangerous. She is dependent on others to be washed, dressed and lifted into her wheelchair. Her safety, and sometimes her survival, depend on not displeasing her caregivers. Anyone who is disabled or chronically ill and who has lived in an institution has experienced being at the mercy of others. Angering, frustrating or otherwise upsetting a staff member may mean sitting in wet pants when the urgency to pee could be held no longer. It is important that staff *like* you.

Not only did Lancey not thank me, but with uncensored honesty she expressed her anger, an emotion largely forbidden for a person with such physical dependence (Zola, 1982). Lancey seemed to recognize her lapse and the risk of her error. She quickly recovered the behaviour so ingrained in her and apologized for her transgressions.

In that matter of moments, I too “got a grip.” My tightened posture relaxed. The flash of anger I felt earlier had evaporated. I interrupted her trail of repentances. I spoke to what I sensed lay beneath her apologies. Shaking my head gently, mainly to myself, I firmly and calmly said to her, “Lancey. Stop. I’m all right. You didn’t hurt me. You don’t need to take care of me.” Was my absence of defensiveness confusing to her? She obeyed, but a quizzical look now sat on her face. “Remember yesterday you attended a talk about assertiveness? Well, you’re practising,” I managed to explain. Suddenly, her puzzled and fearful look gave way to a broad grin. She seemed to register that she was not in trouble and that her relationship with me was intact. We sat staring at each other with big smiles for a few moments before she impulsively stretched out her arms to reach for my embrace.

I still shudder to think how close I came to accepting her apologies.

MY RESEARCH DESCRIBED

The participants

I spoke with numerous clinicians in Vancouver, Winnipeg, Toronto and Montreal in the first year of this project. Eventually, seven health care professionals engaged with me in open-ended interviews: three nurses, two doctors and two other practitioners. All provide direct patient care and work in the mainstream health system. Six are women. All identify or live as heterosexuals. Three are Muslim, all of whom had immigrated to Canada. Five are (or pass as) white. All are fluent and articulate in, among other languages, English.

I interviewed each practitioner twice. With one clinician, our exchange continued for another two sessions. These 16 interviews range from 90 minutes to over two hours.

ETHICAL CONSIDERATIONS

CONSENT, HANDLING OF DATA AND PROTECTING PARTICIPANTS’ IDENTITIES

Participants typically signed consent forms after the data was collected, so that they were fully aware of the content when they consented. I described “consent” as an ongoing exercise, and explained that I expected them to assert their choice and to opt out of any question they did not want to discuss for any reason.

I recorded the interviews on a digital recorder. The voice data was then uploaded to my computer, which is accessible only to me, requiring a code to start up the system. I personally transcribed all of the interviews and was always alone when listening to the recordings. The printed transcripts were also accessible only to me. When I discussed my work with members of my support group, I omitted the names from the hard copies. I then created a separate identity file and renamed the transcripts with codes. Kirby, Greaves and Reid's research methods book (2006) was immensely helpful when I was overwhelmed by voluminous data. All interviewees reviewed their transcripts before I included their words in the report.

All names in this report are pseudonyms. Details that did not add to the meaning of the stories were omitted or changed in efforts to further protect the identity of the health professionals I interviewed.

Framework that informed my analysis of the data

This project is informed by the view that the patient-practitioner relationship is one of inherent power difference. One person is seeking help and is therefore dependent and vulnerable, while the other has power, due to their specific knowledge and language and their socially bestowed authority (Brody, 1992) to provide that help. When the concept of professional power is introduced, many practitioners report they do not feel powerful; others are uncomfortable with the notion of their power or flatly deny having it, while yet others describe the burden of their professional responsibilities. The subtleties of power dynamics are not routine topics for education, conferences or discussions in hospital, clinic or health department lunch rooms. Neither does the concept of power figure into medical ethics, as Brody (1992) argued was essential. (The Canadian Medical Association's Code of Ethics, last updated in 2004 (see <http://policybase.cma.ca/PolicyPDF/PD04-06.pdf>), does not mention power in its outline of principles and responsibilities.)

Violence, regardless of its specifics, is inherently an abuse of *power* — whether that power is manifested as physical assault, sexual violation, shaming or humiliation. Violence's impact on people is both immediate and enduring. Because there is a correlation between violence and chronic health problems (Radomsky, 1995), people who have survived abuse interact more frequently with and are more dependent upon the health care delivery system. They therefore encounter this power imbalance between patient and provider more frequently than others do. For a person who has suffered any kind of abuse, each visit to a health provider, regardless of the nature of the visit, has the possibility of being threatening, because of the inherent power imbalance. Too often, these visits re-enact the abuse of power that is so familiar to these patients — however apparently innocuous the interaction may be to the provider. Consequently, the exchange with the practitioner re-traumatizes the person seeking help for their ailment. They may leave feeling disrespected, blamed, shamed or disbelieved. This is particularly so for people with chronic conditions. Re-traumatized, they are not able to follow instructions, represent themselves with confidence or integrate information given to them. The effectiveness of the visit is thus significantly diminished.

My study sought to understand health professionals' experiences as they work with patients. While health care is facing unprecedented pressures due to resource shortages in systems that are already strained, and these contextual issues certainly affect health care workers, my research focussed on the particular emotional challenges inherent in working with people who are in distress.

I held the following questions in mind as I conducted open-ended interviews: How do clinicians understand power in the patient-practitioner relationship? What experiences, theories, knowledge, etc., has shaped that understanding? How does this understanding and awareness shape day-to-day exchanges with patients? What kinds of circumstances are difficult for professionals? When they become frustrated or uncomfortable, how do they recognize this naturally occurring discomfort, and how do they handle it?

Given my overarching perspective, I was particularly curious about practitioners' feelings and awareness of themselves as they interacted with patients. I assume

- that there is a pervasive denial by practitioners of having power over patients;
- that practitioners' emotions matter, and that they influence care whether or not practitioners are aware of them. I assume that it is a danger to self and others when we are not aware of our emotions;
- that not infrequently practitioners feel uncomfortable, particularly when patients are in obvious levels of angst or when they resist our interventions;
- that power abuse is rampant in health care, and that often practitioners unwittingly expect patients to meet their own needs and unresolved issues; and
- that this trend is reversible.

It is my belief that, as practitioners, we are "other-focussed" and typically do not attend to our own emotions and needs. I believe that denial of our inner landscape leads to much of the harm that we inadvertently cause the people we meet in times of their ill health. Deepening our levels of self-awareness not only improves the service we provide to others but also enhances the meaning and satisfaction of our working days.

My power as a researcher

As a clinician, I have been aware of relational power dynamics for some time. However, my awareness of the greater power of the researcher roared inside my head throughout this project, particularly in my interactions with one interviewee who was hesitant to acknowledge the power her role bestowed upon her. During our second interview, I sensed she was naive about her vulnerability as an interviewee. Consciously, I stepped into this dynamic by telling her that my analysis and my writing gave me power over her. As I did, I noticed my parallel struggle to fully assume my authority in this new position. I became aware that if I minimized my power, I might inadvertently breach her trust. Ironically, until I spoke out loud about the power I held over this interviewee, I hadn't truly acknowledged it to myself. Of the inherent power in unequal relationships, Marilyn Peterson (1992) explains,

Even when we do not *feel* [emphasis hers] powerful, having more power creates the obligation to be aware of our impact on our clients. The burden imposed by this responsibility restricts our freedom, because we have to put the client first in the relationship. Keeping ourselves mindful of our greater power exposes the tension internal to us that inherently churns within the relationship. (p. 53)

With this new awareness, I became more transparent in the interviews that followed.

GETTING BACK TO LANCEY: MY PRACTITIONER-SELF UNMASKED

As part of my research, I reflected on my experience with Lancey. The feelings and reactions I recalled resembled those that emerged in the practitioner interviews.

I remember needing to see myself as creative and as different from other practitioners. I was filled with confidence and certainty about my approach with Lancey. I wanted to feel competent and be appreciated, so I was caught off guard and interrupted by Lancey's reaction. To my embarrassment, it never occurred to me that I might be mistaken. I don't recall if Lancey even thought she had a problem. She did have needs, however, that I had completely missed until I looked up from reading aloud. Lancey could not contain her "good patient" self any longer and she burst, claiming a most urgent need: namely, not to be coerced by me.

What I expand upon here took place in mere fractions of moments. Had my needs prevailed in that instant of registering her distress and feeling awful, I likely would have accepted her apology. I would then probably have reassured her that I was not really upset with her. After a few possibly awkward moments, I suspect I would have carried on with what I thought was my popular education session.² We would have got back to "being nice," and I'd have presumed we were collaborating. Lancey's minor outburst would have slid easily to the background. I doubt she'd have "slipped" again. Swallowing her anger, she would have returned to being the good patient and I would have continued pretending we were on equal footing with her "consent" to proceed. All would have appeared "in control." As the expert, I would have assumed that what I was doing was for her own good, that I was "empowering"³ this woman. By accepting her apology, I would have been allowing her to tend to my feelings.

I so desired shedding that uncomfortable feeling. It was disquieting to be the recipient of anger, and I was jarred by witnessing her fear of me. By accepting her apology, I would not have had to reflect on what I did to cause her distress. Ironically, had I been unable to tolerate my own discomfort, perhaps I'd have squelched this woman's expression of her personal power⁴, even though claiming her agency was precisely what I hoped my approach might facilitate. Accepting her apology would have confirmed that *she* did something wrong. It would have obliterated the healing moment that was possible.

The significant though subtle exchange that transpired between us, prompted by my not accepting her apology, occurred *because* of my authority over Lancey. This story is all about power. She deferred to me and saw me as the expert (Peterson, 1992). At the moment of realizing that she was afraid of me, part of me wanted to deny that fear. What "clicked" was my noticing that it was inappropriate to expect her to reassure me. That time, I didn't let my needs overshadow hers. I shifted gears and stepped fully into my power over her. I knew that she was vigilantly focussed on me and was listening carefully to my every word, so I was conscious of my posture as I spoke gently but firmly. I wanted to use all my powers to tell her she had a right to her anger, a right not to feel pushed by someone more powerful than she was. I wanted her anger at me to be met with gentleness, not defensiveness or patronage.

I did not have the analysis at the time that I provide here. I didn't think then in terms of boundaries or power differential. I believe what ignited my awareness was hearing the indignant, albeit fleeting, voice in my head that barked, "Has she no idea what I am doing for her?" I knew Lancey didn't deserve my self-righteous anger. I shuddered to think how close I came to accepting

her apology, I now realize, because it's one thing to make a mistake that causes distress to someone I hope to help and quite another to deny that I've done any harm. By accepting her apology, I'd have agreed with her that she had done something wrong. (Abuse survivors too often feel responsible for harm done to them.) Had I figured that out too late, I'd be carrying the additional burden of shame at having her hold the responsibility for an error that was mine.

Shame is a terrible albatross to carry, an altogether debilitating emotion. A common by-product of surviving violence, it is a scar that runs much deeper than broken bones. If we want to welcome the whole patient into the clinic and the whole learner into the classroom, if we are to acknowledge and practise responsible use of our power, perhaps it is the cycle of shame that we, as practitioners, must break. How can we support one another when we make mistakes? How can we support one another to be in touch with our emotions so that we can use them for the rich resources of information they are?

LITERATURE REVIEW

As part of doing my research, I conducted a literature review. I include it here to provide context for my work.

Meier, Back and Morrison (2001) noted that if "physicians' inevitable emotions are not acknowledged, there can be unintended consequences" (p. 3007) and that the "most visible consequence of unexamined emotions is compromised patient care" (p. 3008). They go on to say,

It is both universal and normal for physicians to have feelings about their patients. Acceptance and awareness of this phenomenon are prerequisites to the self-knowledge and self-control required in a professional patient-physician relationship. (p. 3008)

To avoid the discomfort brought on by feeling inadequate, emotionally drained or irritable, clinicians may withdraw from patients. They may "go away," as one of the practitioners I interviewed described it, or send the patient away. In his book *What Dying People Want*, David Kuhl (2002) explains,

If I want to be a compassionate physician and not cause harm, then I must address my feelings. Any emotion that I have not recognized or expressed is likely to be projected onto my patient, potentially adding to his suffering. The patient will experience my avoidance, fear, guilt, sense of failure, and other denied emotions as a deliberate failure to engage them as a human being, a deliberate decision to disregard the meaning and importance of their life. They will feel that I abandoned them at the very moment they needed me most. (p. 56)

Many years earlier, Howard Stein (1985) wrote that practitioners must be diligent not to confuse their internal needs with the clinical situations and people around them. He didn't minimize, however, the cost to the practitioner of empathetic engagement with people in distress.

Here lies both the promise and the danger, for to feel along with another we also feel within ourselves... Inhibition against empathizing with another can be interpreted to mean that what we are afraid to find out about ourselves, we do not want to know about another. (p. 20)

Acknowledging that patient care can be anxiety-provoking for the practitioner, he identified the repertoire of human defences practitioners invoke “reflexively to ward off psychological pain, conflicting or incompatible ideas, or feelings of helplessness or danger” (p. 2). He illustrates that if health providers analyze their defenses (best done in the safe presence of a trusted and competent mentor or colleague) and uncover that which disturbs them, they not only learn much about themselves and the world around them, but the care they provide to others improves.

Dr. Rita Charon (2006) also advocates that practitioners engage in self-reflection. In *Narrative Medicine: Honoring the Stories of Illness*, Charon states that the discomfort many health professionals experience around emotion cripples their ability to take a thorough history. She found that practitioners typically interrupt patients when they feel awkward with the emotions the patient expresses and redirect patients to “furnish only medically relevant information in the order dictated by the doctor’s outline” (p. 98). She says this “streamlining sacrifices information of the most valuable sort” (p. 99). Trained in literary studies, Dr. Charon teaches medical students how to listen for narrative, so that this skill becomes an essential tool for physicians in practising medicine. She teaches practitioners to write a “parallel chart.” To differentiate what is appropriate for the parallel chart as opposed to the official patient record, she instructs students that:

If your patient dying of prostate cancer reminds you of your grandfather, who died of that disease last summer, and each time you go into the patient’s room, you weep for your grandfather, you cannot write that in the hospital chart. We will not let you. And yet it has to be written somewhere. You write it in the Parallel Chart. (p. 156)

Asked to write at least one entry per week in this chart, students come together in her classes and read selected entries aloud. In this way, they come to know themselves in their work and to distinguish their own feelings and desires from those of the patients. They also learn that their feelings are not theirs alone. Narrative medicine is bearing witness. And, says Charon, “Bearing witness requires community” (p. 197).

Arthur Frank (1995) also writes eloquently about the imperative of providers to listen to the narratives of illness. Illness, and certainly violence, create chaos in our lives and our bodies. At times, it can be so distressing for the listener to be in the presence of chaos that they are unable to hear these stories. Clinicians may try to distance themselves from the stories because, if they identify with them, they see how “easily any of us could be sucked under” (p. 97). Frank explains that the tales of chaos are “too threatening. The anxiety these stories provoke inhibits hearing” (p. 98). Chaos is messy. Disjointed. Jarring. We’d rather the tale be one of resiliency, of rising above suffering, because the immediacy and cacophony of chaos are too disturbing. But when we rush people along as practitioners, or try to tidy up and make sense of that which is out of control, we deny the experience of the speaker. The worst thing medical providers can do to someone living in chaos is to rush them, says Frank.

Moving on is desirable; chaos is the pit of narrative wreckage. But attempting to push the person out of this wreckage only denies what is being experienced and compounds the chaos. (p. 110)

Frank calls for an “enhanced tolerance for chaos as part of a life story” (p. 111). Examples of this enhanced tolerance emerge in some of my interview excerpts later in this report.

REFLECTIONS ON POWER AND DISCOMFORT

To deny or ignore one's power, when one actually does have it, is not the likeliest road to morality. (Ketchum & Pierce in Brody, 1992, p. 32)

Our understanding of patient-professional power dynamics dictates how we conduct ourselves as practitioners, how we understand our primary role and where we focus our attention. Inherent in this discussion about power differential is the practitioner's overarching awareness of their impact on patients. How might patients see us?

Few of us are taught to be conscious of our reactions in our daily relationships with others or to notice how our behaviour affects those around us. When we are in positions of power, however, this consciousness becomes critical to making us effective in our roles and to ensuring that we don't abuse that power. The professional's primary role is to use their specialized skill and knowledge to provide a service to the patient. Abuses of power, or violations of the patient's boundaries, not only arise from overt acts but also evolve from the dynamics in the relationship. Peterson (1992) states that detecting boundary violations is difficult. Violations are a frequent occurrence because they are a "process rather than a single event" (p. 72). They happen when the core intent of the relationship is breached, namely when the needs of practitioners are met at the expense of the patient (p. 75).

Physician and bestselling author Gabor Maté (2008) explains the importance of knowing ourselves in that power in his latest book on addictions:

The work can be intensely satisfying or deeply frustrating, depending on my own state of mind ... Much as I want to accept them [patients with drug addictions], at least in principle, some days I find myself full of disapproval and judgment, rejecting them and wanting them to be other than who they are. That contradiction originates with me, not with my patients. It's my problem — except that, given the obvious power imbalance between us, *it's all too easy for me to make it their problem*. (p. 13, emphasis mine)

A general distinction between curing and healing may be helpful here, to guide our attention when we come to my interviewees' reflections on their work. To distinguish curing from healing, one needs to also differentiate illness from disease. Illness is the "innately human experience of symptoms and suffering" (Kleinman, 1988, p. 3). Illness is the person's lived experience of breathlessness, pain or weakness. Disease is "what the practitioner creates in the recasting of illness in terms of theories of disorder. Disease is what practitioners have been trained to see through the theoretical lenses of their particular form of practice" (Kleinman, 1988, pp. 4-5). Eric Cassell (1976), a frequently quoted physician on patient-physician dynamics, uses the example of a patient with pneumonia to explain this critical difference. If a doctor does not know the difference between disease and illness, then helping the patient feel better is nothing more than using medicines to kill the bacteria and reduce the fever, which eases breathing. This doctor focusses on curing the disease of pneumonia. They attempt to fix what they identify as "the problem." The physician who learns how the pneumonia affects a given patient will also address the fear, sense of isolation, dependency or whatever other suffering this illness may be causing the person. These latter aspects of the professional's work constitute their healing functions. Hence, even in the case of incurable disease, the practitioner can heal or reduce a person's suffering. While technical advances

have boosted medicine's curing capacity, Cassell argues that there has been a consequent disappearance in the healing part of the practitioner's work (p. 16).

Perhaps clinicians who focus on patient "compliance" and "motivation" are evidence of the system's orientation to curing instead of healing functions. Kleinman (1988) proposed what would amount to a radical change in orientation by suggesting the "practitioner [become] a moral witness, neither a judge nor a manipulator" (p. 246). He explained that such a shift could "change the expectations of the system and may also shake the caregiver out of a pattern of behaviour that does more to maintain the problem than to solve it" (p. 249). In a healing orientation, how the patient experiences their illness remains a focus of curiosity for the clinician. Holding this interest may lessen the clinician's judgement of the patient's "motivation" to get well and their "compliance" with the clinician's intervention regimes.

As will be evident from the interview excerpts that follow, the practitioner's journey to consciousness and to broadening their orientation to address healing varies depending on, among other things, their childhood and life experiences, their professional training and the resources they have to support this effort.

THE DATA ANALYZED

How do these practitioners understand power in patient-practitioner relationships?

The health providers I interviewed had different notions of patient-practitioner power dynamics. For those who viewed power primarily as something to be exercised, images of control and domination, namely of abuse of authority, came to mind. Although they later identified positive examples of using power, these practitioners initially expressed discomfort and were ready to disavow themselves of this element of their role. Power in this interpretation is seen as something that practitioners "do," and it can be good or bad. Said one woman I interviewed, *"I don't want to have power over people. I don't."*

This 37-year-old nurse, with about eight years of experience, I'll call Grace. A white woman who is married with young children, she describes herself as fifth- or sixth-generation Canadian. She hadn't thought about power in the context of her work: *"I think the only time I am ever really conscious of power is in my own home. Children teach you a whole lot you don't want to learn, that you don't want to look at."* She described power as that which you could "do" to or for another person:

I'm the nurse, and I can kick you out of my clinic if I feel like it. I don't have to see you if I don't feel like it... Power can be both [good and bad]. I am the nurse here, I have the power to persuade another practitioner to book you in, and I can get you there.

Grace wants to be diligent in how she exercises her authority. Reflecting on her role as both mother and nurse, she said, "I want to be able to use it well, but I have caught myself being the big powerful mother."

Nusrat is 49 years old and has been a health professional for about 16 years. She is a married mother of school-age children. A Muslim woman, she immigrated to Canada as a child and trained in her profession here. Nusrat seemed to conceptualize power primarily as either a good or a bad thing, depending on how it is used.

